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September 29, 2006

Joseph M. Mahaney, Esq.
Goguen, McLaughlin, Richards & Mahaney, P.C.
The Harrier Beecher Stowe House
2 Pleasant Street
South Natick, MA 01760

Re: Steven McDermott et al. vs. FedEx Ground Package System, Inc. et al.
U.S.D.C. District of Massachusetts C.A. No.: 1:04-CV-12253-JLA

Dear Joe:

This will confirm that we have provided you on August 9, 2006 with a HIPAA release for Dr. Krishna Nirmel's records for your client's signature. As of today, we have not received the signed HIPAA release.

Also, enclosed please find HIPAA releases for the following providers, which have refused to release plaintiff's medical records unless provided with a signed HIPAA release:

1. Herbert Cares, M.D.;
2. Surgical Neurology;
3. Nancy Altman; and
4. Wayside Metrowest Counseling Center.

Please forward the signed releases to my attention at your earliest convenience as it takes time to obtain the records.

If we do not receive the signed releases within one week, we will file a motion for a Court Order to obtain one.

Thank you.

Very truly yours,

Adam Larson | ir

Adam A. Larson

/ir
Enc.
cc: Michael Brown, Esq.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize Krishna N. Nirmel, M.D. (Name of hospital/physician) to use or disclose the following protected information from the records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [redacted]
Social Security #: [redacted]
Address: 175 Mechanic Street
Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C. (Name)
1 Constitution Plaza (Address) Boston (City) MA (State) 02129 (Zip)

4. Disclose the following information for treatment dates: 1995 to Present
(circle appropriate categories)

X Complete Records	X X-Ray
X Abstract	X Laboratory
X Face Sheet	X Pathology
X Discharge Summary	X Physical Therapy
X History and Physical	X Emergency Reports
X Consult	X Psychotherapy Records
X Outpatient Reports	X Other specified **All radiology films*

5. The above information is disclosed for the following purposes: (circle appropriate categories)

Medical Care Legal Insurance Personal At request of the individual Other _____

6. I understand that I may revoke authorization at any time by requesting such of the above referenced hospital or physician practice in writing unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the same full force and effect as if it were itself the original.

9. _____
Signature of Patient or Legal Representative

10. _____
Date

Steven McDermott
Printed name of patient
or patient's representative

11. _____
Relationship to patient or
authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize Herbert Cares, M.D. (Name of hospital/physician) to use or disclose the following protected information from the records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [redacted]
Social Security #:
Address: 175 Mechanic Street
Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C.
Name

1 Constitution Plaza	Boston	MA	02129
Address	City	State	Zip

4. Disclose the following information for treatment dates: 1995 to Present
(circle appropriate categories)

X Complete Records	X X-Ray
X Abstract	X Laboratory
X Face Sheet	X Pathology
X Discharge Summary	X Physical Therapy
X History and Physical	X Emergency Reports
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X Outpatient Reports	X Other specified **All radiology films*

5. The above information is disclosed for the following purposes: (circle appropriate categories)

Medical Care Legal Insurance Personal At request of the individual Other _____

6. I understand that I may revoke authorization at any time by requesting such of the above referenced hospital or physician practice in writing unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the same full force and effect as if it were itself the original.

9. _____
Signature of Patient or Legal Representative

10. _____
Date

Steven McDermott
Printed name of patient
or patient's representative

11. _____
Relationship to patient or
authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize Surgical Neurology (Name of hospital/physician) to use or disclose the following protected information from the records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
Date of Birth: [redacted]
Social Security #:
Address: 175 Mechanic Street
Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C. (Name)

1 Constitution Plaza (Address) | Boston (City) | MA (State) | 02129 (Zip)

4. Disclose the following information for treatment dates: 1995 to Present
(circle appropriate categories)

- X Complete Records
- X Abstract
- X Face Sheet
- X Discharge Summary
- X History and Physical
- X Consult
- X Outpatient Reports
- X X-Ray
- X Laboratory
- X Pathology
- X Physical Therapy
- X Emergency Reports
- X Psychotherapy Records
- X Other specified **All radiology films*

5. The above information is disclosed for the following purposes: (circle appropriate categories)

Medical Care Legal Insurance Personal At request of the individual Other _____

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7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the same full force and effect as if it were itself the original.

9. _____
Signature of Patient or Legal Representative

10. _____
Date

Steven McDermott
Printed name of patient
or patient's representative

11. _____
Relationship to patient or
authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize Nancy Altman (Name of hospital/physician) to use or disclose the following protected information from the records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
   Date of Birth: [redacted]
   Social Security #:
   Address: 175 Mechanic Street
   Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C.
   Name

1 Constitution Plaza	Boston	MA	02129
Address	City	State	Zip

4. Disclose the following information for treatment dates: 1995 to Present
   (circle appropriate categories)

X Complete Records	X X-Ray
X Abstract	X Laboratory
X Face Sheet	X Pathology
X Discharge Summary	X Physical Therapy
X History and Physical	X Emergency Reports
X Consult	X Psychotherapy Records
X Outpatient Reports	X Other specified **All radiology films*

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7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the same full force and effect as if it were itself the original.

9. _____
   Signature of Patient or Legal Representative

10. _____
    Date

Steven McDermott
Printed name of patient
or patient's representative

11. _____
    Relationship to patient or
    authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize Wayside Metrowest Counseling Center (Name of hospital/physician) to use or disclose the following protected information from the records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: Steven McDermott
   Date of Birth: [redacted]
   Social Security #: [redacted]
   Address: 175 Mechanic Street
   Bellingham, MA 02019

3. Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C. (Name)

   1 Constitution Plaza (Address) | Boston (City) | MA (State) | 02129 (Zip)

4. Disclose the following information for treatment dates: 1995 to Present
   (circle appropriate categories)

X Complete Records	X X-Ray
X Abstract	X Laboratory
X Face Sheet	X Pathology
X Discharge Summary	X Physical Therapy
X History and Physical	X Emergency Reports
X Consult	X Psychotherapy Records
X Outpatient Reports	X Other specified **All radiology films*

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7. This authorization expires upon termination of the litigation.

8. I further authorize you to accept either an original or a photostatic copy of this authorization, each having the same full force and effect as if it were itself the original.

9. _____
   Signature of Patient or Legal Representative

10. _____
    Date

Steven McDermott
Printed name of patient
or patient's representative

11. _____
    Relationship to patient or
    authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED